POLICY: ADVANCE DIRECTIVES

POLICY STATEMENT: It is the policy of the Division of Developmental Disabilities and Rehabilitative Services (DDRS) to support Individuals receiving supported living services in their decisions related to advanced directives.

DETAILED POLICY STATEMENT:

Adherence to federal and Indiana statutes:
Nothing in this policy shall be used to subvert or otherwise avoid compliance with federal and Indiana statutes.

Legal requirements for completion of advance directives:
Advance directives are legally binding when prepared by a competent adult, 18 years or age or older.

Individualized support team discussion of advance directives:

A. The individual's case manager shall:
    1. Ensure that the individualized support team (IST) for an individual meeting requirements to complete advance directives:
        a. discusses advance directives with the individual:
            i. annually at the individual's individualized support plan (ISP) meeting; and
            ii. upon notification to the individual of a terminal diagnosis;
        b. assists the individual in selecting a trusted helper who will work with the individual to better understand advance directives and, if the individual so chooses, prepare advance directive documents.
    2. Ensure that the individual and all members of the individual's IST understand that any advance directive signed by the individual is voluntary and may be cancelled by the individual at will.
    3. Document in case notes and in the ISP, the IST discussion of advance directives, including identification of a trusted helper when the individual so chooses.

When an individual elects to prepare advance directives

A. Upon the decision by the individual to prepare advance directives, the individual's case manager shall:
    1. collaborate with the trusted helper chosen by the individual to ensure the individual is assisted with:

a. understanding advance directive options as described the Indiana State Department of Health's document titled "Advance Directives, Your Right to Decide" (Attachment "A");
b. completing one or more of the following advance directive documents per the individual's choosing, including the signatures of witnesses as indicated:
    i. Indiana Appointment of Health Care Representative (Attachment "B");
    ii. Living Will Declaration (Attachment "C");
    iii. Life Prolonging Procedures Declaration (Attachment "D");
    iv. Organ Donor Card (Attachment "E");
c. understanding:
    i. that any or all of the advance directive documents may be cancelled if the individual changes their mind about any advance directive decision; and
    ii. how to cancel one or more of the advance directive documents upon deciding to do so ;

2. call a team meeting should the individual wish to execute a Health Care Power of Attorney advance directive option, and discuss the need for an attorney's services to do so;
3. ensure copies of all signed advance directive documents are provided to the individual's:
    a. health care representative, if indicated;
    b. immediate family members;
    c. personal physician;
    d. medical specialists providing services to the individual;
    e. the individual's attorney, if indicated;
    f. all supported living services providers;

B. The individual's supported living services providers shall ensure employees providing services to the individual are trained on the individual's advanced directives.

Executing advance directives:

A. All entities providing services to the individual shall comply with the advance directives the individual has put in place.

DEFINITIONS:

"Competent adult" means a person 18 years or older having the ability to manage their own affairs.

"Trusted Other" means a person selected by an individual to assist the individual in understanding advance directives and, when the individual so chooses, to prepare advance directives documents per the individual's preferences and decisions.

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REFERENCES:

Indiana State Department of Health, 2004. Advance Directives - Your Right to Know,
IC 29-2-16.1: Revised Uniform Anatomical Gift Act
IC 16-36: Medical Consent
IC 16-36-4: Living wills and Life Prolonging Procedures
IC 30-5-5: Powers
460 IAC 6: Supported Living Services and Supports
460 IAC 7: Individualized Support Plan

Approved by: Julia Holloway, DDRS Director {date}

Attachment "A"

Indiana State Department of Health

2 North Meridian Street
Indianapolis, Indiana 46204

March 1999
Revised May 2004

ADVANCE DIRECTIVES
YOUR RIGHT TO DECIDE

The purpose of this brochure is to inform you of ways that you can direct your medical care and treatment in the event that you are unable to communicate for yourself. This brochure covers:

- What is an advance directive?
- Are advance directives required?
- What happens if you do not have an advance directive?
- What are the different types of advance directives?

THE IMPORTANCE OF ADVANCE DIRECTIVES

Each time you visit your physician, you make decisions regarding your personal health care. You tell your doctor (generally referred to as a "physician") about your medical problems. Your physician makes a diagnosis and informs you about available medical treatment. You then decide what treatment to accept. That process works until you are unable to decide what treatments to accept or become unable to communicate your decisions. Diseases common to aging such as dementia or Alzheimer's disease may take away your ability to decide and communicate your health care wishes. Even young people can have strokes or accidents that may keep them from making their own health care decisions. Advance directives are a way to manage your future health care when you cannot speak for yourself.

WHAT IS AN ADVANCE DIRECTIVE?

"Advance directive" is a term that refers to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives.

Advance directives are normally one or more documents that list your health care instructions. An advance directive may name a person of your choice to make health care choices for you when you cannot make the choices for yourself. If you want, you may use an advance directive to prevent certain people from making health care decisions on your behalf.

Your advance directives will not take away your right to decide your current health care. As long as you are able to decide and express your own decisions, your advance directives will not be used. This is true even under the most serious medical conditions. Your advance directive will only be used when you are unable to communicate or when your physician decides that you no longer have the mental competence to make your own choices.

ARE ADVANCE DIRECTIVES REQUIRED?

Advance directives are not required. Your physician or hospital cannot require you to make an advance directive if you do not want one. No one may discriminate against you if you do not sign one. Physicians and hospitals often encourage patients to complete advance directive documents. The purpose of the advance directive is for your physician to gain information about your health care choices so that your wishes can be followed. While completing an advance directive provides guidance to your physician in the event that you are unable to communicate for yourself, you are not required to have an advance directive.

WHAT HAPPENS IF YOU DO NOT HAVE AN ADVANCE DIRECTIVE?

If you do not have an advance directive and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code § 16-36 allows any member of your immediate family (meaning your spouse, parent, adult child, brother, or sister) or a person appointed by a court to make the choice for you. If you cannot communicate and do not have an advance directive, your physician will try to contact a member of your immediate family. Your health care choices will be made by the family member that your physician is able to contact.

WHAT TYPES OF ADVANCE DIRECTIVES ARE RECOGNIZED IN INDIANA?

- Talking directly to your physician and family
- Organ and tissue donation
- Health care representative
- Living Will Declaration or Life-Prolonging Procedures Declaration
- Psychiatric advance directives
- Out of Hospital Do Not Resuscitate Declaration and Order
- Power of Attorney

TALKING TO YOUR PHYSICIAN AND FAMILY

One of the most important things to do is to talk about your health care wishes with your physician. Your physician can follow your wishes only if he or she knows what your wishes are. You do not have to write down your health care wishes in an advance directive. By discussing your wishes with your physician, your physician will record your choices in your medical chart so that there is a record available for future reference. Your physician will follow your verbal instructions even if you do not complete a written advance directive. Solely discussing your wishes with your physician, however, does not cover all situations. Your physician may not be available when choices need to be made. Other health care providers would not have a copy of the medical records maintained by your physician and therefore would not know about any verbal instructions given by you to your physician. In addition, spoken instructions provide no written evidence and carry less weight than written instructions if there is a disagreement over your care. Writing down your health care choices in an advance directive document makes your wishes clear and may be necessary to fulfill legal requirements.

If you have written advance directives, it is important that you give a copy to your physician. He or she will keep it in your medical chart. If you are admitted to a hospital or health facility, your physician will write orders in your medical chart based on your written advance directives or your spoken instructions. For instance, if you have a fatal disease and do not want cardiopulmonary resuscitation (CPR), your physician will need to write a "do not resuscitate" (DNR) order in your chart. The order makes the hospital staff aware of your wishes. Because most people have several health care providers, you should discuss your wishes with all of your providers and give each provider a copy of your advance directives.

It is difficult to talk with family about dying or being unable to communicate. However, it is important to talk with your family about your wishes and ask them to follow your wishes. You do not always know when or where an illness or accident will occur. It is likely that your family would be the first ones called in an emergency. They are the best source of providing advance directives to a health care provider.

ORGAN AND TISSUE DONATION

Increasing the quality of life for another person is the ultimate gift. Donating your organs is a way to help others. Making your wishes concerning organ donation clear to your physician and family is an important first step. This lets them know that you wish to be an organ donor. Organ donation is controlled by the Indiana Uniform Anatomical Gift Act found at Indiana Code § 29-2-16. A person that wants to donate organs may include their choice in their will, living will, on a card, or other document. If you do not have a written document for organ donation, someone else will make the choice for you. A common method used to show that you are an organ donor is making the choice on your driver's license. When you get a new or renewed license, you can ask the license branch to mark your license showing you are an organ donor.

HEALTH CARE REPRESENTATIVE

A "health care representative" is a person you choose to receive health care information and make health care decisions for you when you cannot. To choose a health care representative, you must fill out an appointment of health care representative document that names the person you choose to act for you. Your health care representative may agree to or refuse medical care and treatments when you are unable to do so. Your representative will make these choices based on your advance directive. If you want, in certain cases and in consultation with your physician, your health care representative may decide if food, water, or respiration should be given artificially as part of your medical treatment.

Choosing a health care representative is part of the Indiana Health Care Consent Act, found at Indiana Code § 16-36-1. The advance directive naming a health care representative must be in writing, signed by you, and witnessed by another adult. Because these are serious decisions, your health care representative must make them in your best interest. Indiana courts have made it clear that decisions made for you by your health care representative should be honored.

LIVING WILL

A "living will" is a written document that puts into words your wishes in the event that you become terminally ill and unable to communicate. A living will is an advance directive that lists the specific care or treatment you want or do not want during a terminal illness. A living will often includes directions for CPR, artificial nutrition, maintenance on a respirator, and blood transfusions. The Indiana Living Will Act is found at Indiana Code § 16-36-4. This law allows you to write one of two kinds of advance directive.

Living Will Declaration: This document is used to tell your physician and family that life-prolonging treatments should not be used so that you are allowed to die naturally. Your living will does not have to prohibit all life-prolonging treatments. Your living will should list your specific choices. For example, your living will may state that you do not want to be placed on a respirator but that you want a feeding tube for nutrition. You may even specify that someone else should make the decision for you.

Life-Prolonging Procedures Declaration: This document is the opposite of a living will. You can use this document if you want all life-prolonging medical treatments used to extend your life.

Both of these documents can be canceled orally, in writing, or by destroying the declaration yourself. The cancellation takes effect only when you tell your physician. For either of these documents to be used, there must be two adult witnesses and the document must be in writing and signed by you or someone that has permission to sign your name in your presence.

PSYCHIATRIC ADVANCE DIRECTIVE

Any person may make a psychiatric advance directive if he/she has legal capacity. This written document expresses your preferences and consent to treatment measures for a specific diagnosis. The directive sets forth the care and treatment of a mental illness during periods of incapacity. This directive requires certain items in order for the directive to be valid. Indiana Code § 16-36-1.7 provides the requirements for this type of advance directive.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

In a hospital or health facility setting, if you have a terminal condition and you do not want CPR, your physician will write a "do not resuscitate" order in your medical chart. If you are home when an emergency occurs, there is no medical chart or physician's order. For situations outside of a hospital or health facility, the "Out of Hospital Do Not Resuscitate Declaration and Order" is used to state your wishes. The Out of Hospital Do Not Resuscitate Declaration and Order is found at Indiana Code § 16-36-5. The law allows a qualified person to say they do not want CPR given if the heart or lungs stop working in a location that is not a hospital or a health facility. This declaration may override other advance directives. The declaration may be canceled by you at any time by a signed and dated writing, by destroying or canceling the document, or by communicating to health care providers at the scene the desire to cancel the order. Emergency Medical Services (EMS) may have procedures in place for marking your home so they know you have an order. You should contact your local EMS provider to find out their procedures.

POWER OF ATTORNEY

A "power of attorney" (also referred to as a "durable power of attorney") is another kind of advance directive. This document is used to grant another person say-so over your affairs. Your power of attorney document may cover financial matters, give health care authority, or both. By giving this power to another person, you give this person your power of attorney. The legal term for the person you choose is "attorney in fact." Your attorney in fact does not have to be an attorney. Your attorney in fact can be any adult you trust. Your attorney in fact is given the power to act for you only in the ways that you list in the document. The document must:

1. Name the person you want as your attorney in fact;
2. List the situations which give the attorney in fact the power to act;
3. List the powers you want to give; and
4. List the powers you do not want to give.

The person you name as your power of attorney is not required to accept the responsibility. Prior to executing a power of attorney document, you should talk with the person to ensure that he or she is willing to serve. A power of attorney document may be used to designate a health care representative. Health care powers are granted in the power of attorney document by naming your attorney in fact as your
health care representative under the Health Care Consent Act or by referring to the Living Will Act. When a power of attorney document is used to name a health care representative, this person is referred to as your health care power of attorney. A health care power of attorney generally serves the same role as a health care representative in a health care representative advance directive. Including health care powers could allow your attorney in fact to:

1. Make choices about your health care;
2. Sign health care contracts for you;
3. Admit or release you from hospitals or other health facilities;
4. Look at or get copies of your medical records; and
5. Do a number of other things in your name.

The Indiana Powers of Attorney Act is found at Indiana Code § 30-5. Your power of attorney document must be in writing and signed in the presence of a notary public. You can cancel a power of attorney at any time but only by signing a written cancellation and having the cancellation delivered to your attorney in fact.

WHICH ADVANCE DIRECTIVE OR DIRECTIVES SHOULD BE USED?

The choice of advance directives depends on what you are trying to do. The advance directives listed above may be used alone or together. Although an attorney is not required, you may want to talk with one before you sign an advance directive. The laws are complex and it is always wise to talk to an attorney about questions and your

legal choices. An attorney is often helpful in advising you on complex family matters and making sure that your documents are correctly done under Indiana law. An attorney may be helpful if you live in more than one state during the year. An attorney can advise you whether advance directives completed in another state are recognized in Indiana.

CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?

It is important to discuss your advance directives with your family and health care providers. Your health care wishes cannot be followed unless someone knows your wishes. You may change or cancel your advance directives at any time as long as you are of sound mind. If you change your mind, you need to tell your family, health care representative, power of attorney, and health care providers. You might have to cancel your decision in writing for it to become effective. Always be sure to talk directly with your physician and tell him or her your exact wishes.

ARE THERE FORMS TO HELP IN WRITING THESE DOCUMENTS?

Advance directive forms are available from many sources. Most physicians, hospitals, health facilities, or senior citizen groups can provide you with forms or refer you to a source. These groups often have the information on their web sites. You should be aware that forms may not do everything you want done. Forms may need to be changed to meet your needs. Although advance directives do not require an attorney, you may wish to consult with one before you try to write one of the more complex legal documents listed above.

WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?

Make sure that your health care representative, immediate family members, physician, attorney, and other health care providers know that you have an advance directive. Be sure to tell them where it is located. You should ask your physician and other health care providers to make your advance directives part of your permanent medical chart. If you have a power of attorney, you should give a copy of your advance directives to your attorney in fact. You may wish to keep a small card in your purse or wallet that states that you have an advance directive, where it is located, and who to contact for your attorney in fact or health care representative, if you have named one. 7

FINAL THOUGHTS ABOUT ADVANCE DIRECTIVES

- You have the right to choose the medical care and treatment you receive. Advance directives help make sure you have a say in your future health care and treatment if you become unable to communicate.

- Even if you do not have written advance directives, it is important to make sure your physician and family are aware of your health care wishes.

- No one can discriminate against you for signing, or not signing, an advance directive. An advance directive is, however, your way to control your future medical treatment.

- This information was prepared by the Indiana State Department of Health as an overview of advance directives. The Indiana State Department of Health attorneys cannot give you legal advice concerning living wills or advance directives. You should talk with your personal lawyer or representative for advice and assistance in this matter.

Indiana State Department of Health
2 North Meridian Street
Indianapolis, Indiana 46204
http://www.in.gov/isdh

Attachment "B"
Indiana Appointment of Health Care Representative

I, _____, voluntarily appoint the following person as my health care representative. My representative is authorized to act for me in all matters of health care in accordance with IC 16-36-1 and IC 30-5 et. seq., except as otherwise specified below.

_____ _____
Appointed Health Care Representative Address

_____ _____
Telephone Number City

_____ _____
Social Security Number State and Zip Code

I authorize my health care representative to make decisions in my best interest concerning consent to treatment and the withdrawal or withholding of health care. If at any time, based on my previously expresses preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is or would be excessively burdensome, then my health care representative may express my will that such health care would be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician(s) and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

This appointment is to be exercised in good faith and in my best interest subject to the following terms and conditions:

_____

_____

This appointment becomes effective and remains effective if I am incapable of consenting to my own health care. I do authorize my health care representative hereby appointed to delegate decision-making power to another.

Dated this _____ day of _____, year of _____.

_____ _____
Signature Street Address

_____ _____
Print Full Legal Name City, County & State of Residence

_____ _____
Date of Birth Social Security Number

I declare that I am an adult at least eighteen (18) years of age and that at the request of the above named individual making the appointment, I witnessed the signing of this document by the Appointee on the date noted above.

_____ _____
Witness Signature Street Address

_____ _____
Witness (Please Print Full Legal Name) City, County & State of Residence

_____
Telephone Number

Attacment "C"

LIVING WILL DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease, or illness; (2) my death will occur within a short time; and (3) the use of life prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. (Indicate your choice by initialing or making your mark before signing this declaration):

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal

I understand the full import of this declaration.

Signed _____

_____
City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____ Date _____

Witness _____ Date _____

Attacment "D"

LIFE PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____ (month, year). I, _____, being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Signed _____

_____
City, County, and State of Residence

The declarant has been personally known to me, and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness _____ Date _____

Witness _____ Date _____

Attacment "E"
Indiana Appointment of Health Care Representative

I, _____, voluntarily appoint the following person as my health care representative. My representative is authorized to act for me in all matters of health care in accordance with IC 16-36-1 and IC 30-5 et. seq., except as otherwise specified below.

_____	_____
Appointed Health Care Representative	Address
_____	_____
Telephone Number	City
_____	_____
Social Security Number	State and Zip Code

I authorize my health care representative to make decisions in my best interest concerning consent to treatment and the withdrawal or withholding of health care. If at any time, based on my previously expresses preferences and the diagnosis and prognosis, my health care representative is satisfied that certain health care is or would be excessively burdensome, then my health care representative may express my will that such health care would be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result.

My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician(s) and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others, to the extent they are available.

This appointment is to be exercised in good faith and in my best interest subject to the following terms and conditions:

_____
_____

This appointment becomes effective and remains effective if I am incapable of consenting to my own health care. I do authorize my health care representative hereby appointed to delegate decision-making power to another.

Dated this _____ day of _____, year of _____.

_____	_____
Signature	Street Address
_____	_____
Print Full Legal Name	City, County & State of Residence
_____	_____
Date of Birth	Social Security Number

I declare that I am an adult at least eighteen (18) years of age and that at the request of the above named individual making the appointment, I witnessed the signing of this document by the Appointee on the date noted above.

_____	_____
Witness Signature	Street Address
_____	_____
Witness (Please Print Full Legal Name)	City, County & State of Residence
_____	
Telephone Number	